

# **MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE**

**Please answer all questions completely:**

1. Your name and address:

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2. Phone Number: \_\_\_\_\_

3. Please describe the collision in your own words:

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4. Where did the collision occur? City/Town: \_\_\_\_\_ State: \_\_\_\_\_

5. Date of collision: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

6. Were you the:  driver  passenger  pedestrian

7. If passenger, were you in the  front seat  right rear seat  left rear seat

8. What type of vehicle were you in? \_\_\_\_\_

9. What type was the other vehicle? \_\_\_\_\_

10. Did your vehicle strike the other vehicle?  yes  no

11. Was your car struck by the other vehicle?  yes  no

12. What direction was your vehicle going? \_\_\_\_\_

13. What direction was the other vehicle going? \_\_\_\_\_

14. Was the impact from:  the front  the rear  the left side  the right side

15. What was the approximate speed at the time of the impact?

Your vehicle \_\_\_\_\_ mph Other vehicle \_\_\_\_\_ mph

16. What was the weather at the time of the collision?  dry  wet  icy

17. Was your vehicle in:  park  neutral  in gear  moving  stopped

18. Were your brakes being applied?  yes  no

19. Was your vehicle shoved:  forward  backward  sideways

20. Were you shoved:  forward  whipped backward

21. Did your seat have a head restraint (headrest?)  yes  no

22. If yes, what was the position  low  midposition  high
23. Did your head ride over the headrest?  yes  no
24. Did your hat/glasses end up in the back seat or rear window?  yes  no
25. Did any other part of your body hit the interior of the vehicle?  yes  no
26. If yes, please specify:  seatbelt restraints  steering wheel  dashboard  
 windshield  side door  side window  other \_\_\_\_\_
27. Which part of your body?  chest  head  chin  face  R L knee  
 R L shoulder  R L hand  other \_\_\_\_\_
28. Were you holding on to the steering wheel?  yes  no
29. Did you brace your arms against the dash?  yes  no
30. Did you brace your legs against the floorboard?  yes  no
31. Was your ankle turned?  yes  no
32. Did the vehicle go into a spin or roll as a result of the impact?  yes  no
33. If yes, explain: \_\_\_\_\_
34. How much damage was there to the outside of the vehicle?  none  some  a lot
35. How much damage was there to the inside of the vehicle?  none  some  a lot
36. At the point of impact, where did you experience pain? Be specific:  
 \_\_\_\_\_  
 \_\_\_\_\_
37. Immediately after the accident were you:  conscious  dazed  unconscious
38. If you lost consciousness, how long? \_\_\_\_\_
39. Were you wearing a seat belt?  yes  no
40. Did the belt have a shoulder harness?  yes  no
41. If yes, did it contribute to the pain you are experiencing?  yes  no
42. At the time of impact were you:  looking straight ahead  looking to the right  
 looking to the left  looking down  looking up
43. Did the seat break as a result of the impact?  yes  no
44. Were you braced for the impact?  yes  no
45. Were you surprised by the impact?  yes  no
46. Did you go to the hospital?  yes  no
47. If yes, when?  right after the accident  next day  other \_\_\_\_\_

48. If yes, how did you get there?  ambulance other: \_\_\_\_\_

49. If by ambulance, did the ambulance attendants place you in a:  neck brace

back brace  other \_\_\_\_\_

50. Any medication or medical supplies given? \_\_\_\_\_

51. Did you have x-rays taken at the hospital?  yes  no

If you went to the hospital, please answer the following:

Name of hospital \_\_\_\_\_

Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment Received \_\_\_\_\_

\_\_\_\_\_

52. Have you had any similar problems before?  yes  no

53. If yes, explain: \_\_\_\_\_

54. Are you diabetic?  yes  no

55. Do you have high blood pressure?  yes  no

56. Do you have low blood pressure?  yes  no

57. Do you have arthritis or degenerative joint disease?  yes  no

58. What type of work do you do? \_\_\_\_\_

59. What are your job requirements? \_\_\_\_\_

60. Have you lost any days of work from this injury?  yes  no

61. If yes, give dates: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

# PERSONAL INJURY INSURANCE COVERAGE

Date \_\_\_\_\_ Spoke With \_\_\_\_\_ Number \_\_\_\_\_

Patient Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Insured Name \_\_\_\_\_

Date of Accident \_\_\_\_\_

Claim Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Has the accident been reported?  yes  no

Name of adjuster handling claim \_\_\_\_\_

Will company accept assignment of benefits?  yes  no

If not, will they make checks payable to patient and our office?  yes  no

Limits: How much? \$ \_\_\_\_\_ What's left? \_\_\_\_\_

# GROUP HEALTH INSURANCE

Medical benefits under auto insurance?  yes  no

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Insured Name \_\_\_\_\_

Agent \_\_\_\_\_ Policy# \_\_\_\_\_ Phone \_\_\_\_\_

Name and address of other party or parties involved in collision:

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# ATTORNEY INFORMATION

Date \_\_\_\_\_ Spoke With \_\_\_\_\_ Number \_\_\_\_\_

Patient Name \_\_\_\_\_

Attorney Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Does attorney need copies of bills?  yes  no

In the event of settlement, will they protect any unpaid balance?  yes  no

Do they have PIP?  yes  no                      Do we file?  yes  no

Do they have insurance?  yes  no                      Do we file?  yes  no

Can we file liability?  yes  no